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Behavioral Health Utilization Controls – Hospital-based Clinics

Effective April 1, 2011, the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) will establish utilization thresholds for their hospital-based clinics. These thresholds will target unusually high utilization with payment reductions and will be established by the licensing state agency as follows:

For Article 31 clinics licensed by OMH in or operated by general hospitals licensed under Article 28 of the Public Health Law, Medicaid payments shall be subject to the following reductions:

(1) For persons 21 years of age or older at the start of the state fiscal year, payment for the 31st through 50th visits in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 25% reduction in the otherwise applicable payment amount.

(2) For persons 21 years of age or older at the start of the state fiscal year, payment for visits in excess of 50 in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 50% reduction in the otherwise applicable payment amount.

(3) For persons less than 21 years of age at the start of the state fiscal year, payment for visits in excess of 50 in that state fiscal year at one or more clinics operated by the same hospital will be subject to a 50% reduction in the otherwise applicable payment amount.

(4) Off-site visits (rate codes 1519 and 1525), medical visits (rate codes 1588 and 1591) and crisis visits (rate codes 1576 and 1582), when billed under their applicable rate codes, will be disregarded in computing the number of visits pursuant to the preceding paragraphs. For off-site visits provided by OMH-licensed clinics to homeless individuals, Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90(b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OMH-licensed clinics to other than homeless individuals may be reimbursed with State-only funding and will not be claimed for federal financial participation.

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For freestanding Article 31 clinics licensed by OMH and Article 31 clinics in or operated by Diagnostic and Treatment Centers licensed under Article 28 of the Public Health Law, Medicaid payments shall be subject to the following reductions:

(1) For persons 21 years of age or older at the start of the state fiscal year, payment for the 31st through 50th visits in a state fiscal year at one or more clinics operated by the same agency will be subject to a 25% reduction in the otherwise applicable payment amount.

(2) For persons 21 years of age or older at the start of the state fiscal year, payment for visits in excess of 50 in a state fiscal year at one or more clinics operated by the same agency will be subject to a 50% reduction in the otherwise applicable payment amount.

(3) For persons less than 21 years of age at the start of the state fiscal year, payment for visits in excess of 50 in that state fiscal year at one or more clinics operated by the same agency will be subject to a 50% reduction in the otherwise applicable payment amount.

(4) Off-site visits (rate codes 1519 and 1525), medical visits (rate codes 1588 and 1591) and crisis visits (rate codes 1576 and 1582), when billed under their applicable rate codes, will be disregarded in computing the number of visits pursuant to the preceding paragraphs. For off-site visits provided by OMH-licensed clinics to homeless individuals, Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90(b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OMH-licensed clinics to other than homeless individuals may be reimbursed with State-only funding and will not be claimed for federal financial participation.

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For hospital-based Article 32 clinics licensed by OASAS, Medicaid payments shall be subject to the following per person reductions:

(1) Payment for the 76th through 95th visits in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 25% reduction in the otherwise applicable payment amount.

(2) Payment for visits in excess of 95 in a state fiscal year at one or more clinics operated by the same hospital will be subject to a 50% reduction in the otherwise applicable payment amount.

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Behavioral Health Utilization Controls – Freestanding Clinics

Effective April 1, 2011, each of the New York State mental hygiene agencies - the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People with Developmental Disabilities (OPWDD) - will establish utilization thresholds for their freestanding clinics. These thresholds will target unusually high utilization with payment reductions and will be established by the licensing state agency as follows:

For Article 16 clinics licensed by OPWDD, Medicaid payments will be subject to the following reductions:

Service categories and corresponding peer-based monthly utilization thresholds are established as follows: nutrition/dietetics, 2.08; speech language pathology, 4.33; occupational therapy, 4.08; physical therapy, 5.25; rehabilitation counseling, 3.25; individual psychotherapy, 3.08; and group psychotherapy, 3.17.

Using Medicaid paid claims with dates of service within the utilization look-back period, OPWDD will annually compare each Article 16 clinic's monthly utilization rates for the applicable utilization look-back period (as defined later in this section) to the established threshold values for each service category. If the service category threshold was exceeded, OPWDD will calculate the number of visits paid in excess of the threshold value. For the purposes of this section, each unique paid Article 16 Medicaid claim for service rendered during the applicable utilization look-back period will constitute a "visit." The service category monthly utilization rate and excess paid visits will be calculated for each clinic as follows:

Service Category Visits will be the number of paid Medicaid visits within the service category with dates of service within the utilization look-back period. Visits associated with Medicaid recipients who received fewer than four paid visits in a service category during the look-back period will be excluded from this calculation.

Service Category Recipient Months will be the count of unique individuals for whom a claim was paid for services rendered during each specific calendar month of the look-back period. For example, a Medicaid recipient who received paid physical therapy services during each month of a twelve month look-back period contributes 12 recipient months to the clinic's total recipient months. A Medicaid recipient who received paid physical therapy services in only three calendar months within the same twelve month look-back period contributes three recipient months to the clinic's total recipient months. Medicaid recipients who received fewer than four paid visits within the service category during the look-back period will be excluded and will contribute zero recipient months to the clinic's total recipient months.

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Service Category Monthly Utilization Rate will be equal to the service category visits divided by the service category recipient months.

Service Category Excess Visits. If the clinic's service category monthly utilization rate was below the established threshold, the service category excess visits will be zero. Otherwise, the service category excess visits will be equal to the difference between service category monthly utilization rate and the service category threshold, multiplied by the service category recipient months. That is, excess visits = (monthly utilization rate – threshold) * recipient months.

Total Excess Visits As % of Total Paid Visits. Each clinic's excess visits will be summed across all service categories and calculated as a percentage of total paid Article 16 Medicaid visits (claims) with service dates within the utilization look-back period. For this purpose, the divisor, "total paid visits," will be a count of all unique claims paid under Article 16 rate codes with service dates within the utilization look-back period. The divisor will include visits for services for which threshold values have not been established (e.g., psychological and developmental testing visits, physician evaluation/assessment visits, etc.), if the clinic rendered any such visits.

The reimbursement rates of clinics with excess visits will be reduced by a uniform percentage as follows:

Total Excess Visits As % Of Total Paid Visits	Percent Rate Reduction
15.1% or more	5.00%
10.1% to 15.0%	4.25%
5.1% to 10.0%	3.50%
1.0% to 5.0%	2.75%
Less than 1.0%	0.00%

For the period April 1, 2011, to June 30, 2011, the percentage rate reductions will be applied to the rates established for each of the twelve visit types authorized by OPWDD regulations during that period. For the period beginning July 1, 2011, onward, the percentage rate reductions will be applied to the clinic's Article 16 APG base rate, Article 16 APG average legacy fee, and the Article 16 APG capital add-on.

Utilization look-back periods associated with each rate reduction period will be as follows:

Rate Reduction Period (State Fiscal Year)	Utilization Look-back Period
4/1/2011 to 3/31/2012	1/1/2009 to 12/31/2009
4/1/2012 to 3/31/2013	7/1/2011 to 12/31/2011
4/1/2013 to 3/31/2014	10/1/2011 to 9/30/2012

Beginning state fiscal year 2014-2015, and each subsequent state fiscal year thereafter, the utilization look-back period will be the period used in the preceding state fiscal year advanced by twelve months.

For the period April 1, 2011, through March 31, 2012, OPWDD may waive the reimbursement rate reductions described here, provided, however, that the waiver will be subject to retroactive revocation upon a determination by OPWDD, in consultation with the Department of Health, that the clinic has not complied with the terms of such waiver. Such terms are:

(i) In order to receive a waiver, a clinic must submit to OPWDD a request for a waiver and a utilization reduction plan. OPWDD will grant the waiver if the clinic's utilization reduction plan shows a reduction in the clinic's planned state fiscal year 2011-2012 Medicaid visits by an amount equal to the paid visits in excess of the utilization thresholds and if the clinic is operating in conformance with all applicable statutes, rules and regulations. For purposes of this section, a clinic's planned state fiscal year 2011-2012 visits cannot exceed its paid Medicaid visits in calendar year 2010.

(ii) OPWDD will compare the actual paid and planned visits between April 1, 2011 and March 31, 2012 for each clinic granted a waiver. If a clinic fails to achieve the reduction in utilization in accordance with its utilization reduction plan, OPWDD will revoke the waiver and reduce the clinic's reimbursement rates for state fiscal year 2011-12 as computed in accordance with the provisions of this section, provided, however, that such reduction computation will incorporate and reflect any utilization reduction that the clinic did achieve while operating under the waiver.

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For freestanding Article 32 clinics licensed by OASAS, Medicaid payments will be subject to the following per person reductions:

(1) Payment for the 76th through 95th visits in a state fiscal year at one or more clinics operated by the same agency will be subject to a 25% reduction in the otherwise applicable payment amount.

(2) Payment for visits in excess of 95 in a state fiscal year at one or more clinics operated by the same agency will be subject to a 50% reduction in the otherwise applicable payment amount.